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# Being Stalked: A Psychiatrist's Perspective

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## Abstract

*It is only recently that stalking has been criminalized after some highly publicized forensic cases. Psychiatric focus has been on erotomania, and in this article we primarily highlight stalking as a separate entity with psychiatric and legal implications. The case reports reveal our vulnerability as therapists, and we hope will raise our awareness of stalking as a potentially dangerous situation. The legal statutes vary in different states, but our recommendations may provide guidelines towards formulating policies and procedures for the safety of healthcare providers.*

## INTRODUCTION

The traditional doctor-patient relationship has been scrutinized intensely in recent years. Several instances have been brought to light where the physician has abused his/her power in the role of care-giver to patients, and this has been addressed extensively in the literature (1). The exploitation of patients has always been deemed ethically wrong, and more recently has been examined from the legal perspective. Yet, the reverse situation, where the physician can become a victim of harassment and assault, has rarely been addressed in the literature. There is often reluctance to disclose, on the part of physicians, possibly from fear of revealing vulnerability. There has been an increase in the number of reported incidents of assault against nursing staff, but most cases remain unreported (2). The recent shooting of emergency room staff in the University of South California Hospital, Los Angeles, shatters the assumption of personal safety within our profession.

In psychiatry, we are exposed to violent and threatening patients early in our training, and very quickly we learn strategies in management of patients in these situations. Results from data collected from psychiatric residents who were members of the Canadian Psychiatric Association revealed that 40.2% of residents have been assaulted at least once. In general, assaults on residents and staff tend to be under-reported (3). There are routine security measures in psychiatric facilities and emergency rooms to protect the staff and patients from violence, however, these

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measures may need to be re-examined and upgraded from time to time, as new situations evolve.

### EROTOMANIA

There is very little mention of stalking, as such, in the literature. Stalking has been largely described in the context of erotomania. There have been reports of delusional erotomania, and Segal (4) reviews the historical evolution of this disorder. Kraepelin was the first to describe erotomania, which has also been called *de Clerambault's syndrome*, after the French psychiatrist who described it in detail in 1921. The essential feature of the erotomaniac delusional disorder, as described in the *Diagnostic Statistical Manual-III-Revised (DSM-III-R)* (5), is that the patient believes that he or she is loved by another. The person about whom this conviction is held is usually of higher status, such as a famous person or a superior at work, and may even be a complete stranger. Efforts to contact the object of the delusion, through telephone calls, letters, gifts, visits, and even surveillance and stalking are common, though occasionally the person keeps the delusion secret. Clinical case reports have been predominantly of women, whereas forensic cases mostly involve men (6).

### FORENSIC/LEGAL PERSPECTIVE

Two forensic cases have captured widespread public attention. First was the assassination attempt of Ronald Reagan on March 30, 1981 by John Hinckley, Jr., who was obsessed with the actress Jodie Foster. The second involved Richard Farley, who had stalked a co-worker Laura Black, and eventually wounded her and two others, as well as killed seven people on February 16, 1988 in the silicon valley firm in California that had recently fired him. California, in 1990, became the first state to enact a criminal law that proscribed "stalking," and since then 47 additional states have passed anti-stalking legislation. California enacted its anti-stalking law in response to several highly publicized stalking incidents, including the murder of actress Rebecca Schaeffer by an obsessed fan; the brutal stabbing of actress Theresa Saldana; and murders of four women in Orange County, each of whom had been stalked, had a temporary restraining order against the assailant, and had told their family and friends they thought they were going to be killed.

Morville (7) points out that Hollywood stars are not the only victims of stalking, and that this problem most often occurs in connection with acts of domestic violence. Often, a spurned lover or estranged spouse, who is usually a male, follows and harasses the former partner. Similarly, a battered woman who leaves her abusive partner may become a victim of stalking. Approximately ninety percent of women killed by their husbands or boyfriends are stalked prior to their deaths (8). Prior to the enactment of anti-stalking legislation, the offender usually had to commit an overt attack before he could be arrested or prosecuted. A civil protection order such as a restraining order often offered inadequate protection; moreover most victims

lacked the ability to obtain one. Criminalizing stalking may help deter more violent acts such as deaths, and has been supported by National Organization for Victim Assistance, the National Victims Center, and the National Battered Women's Law Project.

In October 1993, the U.S. Department of Justice's National Institute of Justice (NIJ) (9) developed a model anti-stalking code to encourage states to adopt anti-stalking measures and to provide them with direction in formulating such laws. Stalking is typically defined as willful, malicious, and repeated following and harassing of another person. Many stalking statutes prohibit non-consensual communication. Provisions often require that the victim have a reasonable fear for his or her safety, or a fear of death or bodily injury. The two chief elements of most stalking statutes are threatening behavior and criminal intent of the defendant.

Thirty-three states and the District of Columbia include in the definition of stalking actions that would cause a reasonable person to feel threatened, even if there has been no verbal threat by the perpetrator, while 14 states require that the perpetrator make a threat against the victim. Thirteen states require that the defendant has the intent and/or the apparent ability to carry out the threat. Some states include threats against immediate family members to be presented as evidence of stalking. Most states require that the defendant has the criminal intent to cause fear in the victim, although 13 states do not require this, provided that he or she intends to do the act that results in fear. If the victim is reasonably frightened by the alleged perpetrator's conduct, an element of the crime has been met. It is almost always required that the alleged stalker engage in a "course of conduct." The crime is not an isolated incident, but rather a series of acts taken together. The course of conduct must be "willful," "intentional," or "knowing." Many states have both misdemeanor and felony classifications of stalking. Typically, a stalker convicted of a misdemeanor may receive a jail sentence of up to one year. Felony penalties from three to four years are typical, but some states allow 10- and 20-year sentences (9).

What measures do we have in place to protect health care providers from threats of violence and stalking behavior that may infiltrate into their lives beyond the work place? We will outline two case vignettes which emphasize the importance for health care providers to have issues of safety addressed in the work place, and for hospital administrations to formulate policies and procedures to safeguard the interests of their employees. Both the vignettes have psychiatry residents as the treating physicians, but these situations can be extended to other health care providers such as psychiatric nurses, psychologists and social workers.

#### CASE REPORT #1

Mr. Z, a 40 year old divorced Caucasian, with a history of chronic paranoid schizophrenia, was treated by a male psychiatric resident as an outpatient. During one of his multiple hospitalizations, he was under the care of a female psychiatric resident. His symptoms of severe paranoia and command hallucinations resolved after a 10-day hospitalization. Two weeks after discharge, patient requested readmission to the psychiatric ward, and this

voluntary hospitalization date coincided with the female resident's return to the ward from vacation. It was only during the second admission that the resident was notified that the patient had a past history of harassing and stalking female therapists in a dangerous manner. In supervision, the complexity of the situation was acknowledged but at that point it was felt appropriate for the patient to continue under the female resident's care. After discharge, the patient returned to the care of his outpatient therapist. The day after discharge, Mr. Z sent the resident long-stemmed roses and a letter of marriage proposal.

Mr. Z then attempted to obtain outpatient follow-up care with the resident, and refused to meet with his outpatient therapist. He was told in a meeting with his male therapist and clinic chief that he could either continue care with the male psychiatric resident only, or he could seek care at other psychiatric facilities in the community. Meanwhile, Mr. Z continued to leave several messages for the female resident, sent incoherent letters stating his admiration for her, and long-stemmed roses again.

During the next couple of months, Mr. Z was sighted several times wandering through the clinic building, during the day as well as at night. During these excursions, he left packages, parcels and letters for the female resident. He called the hospital police department and stated that the resident and he were in love, and that his outpatient male therapist was keeping her away from him. Both psychiatric residents repeatedly called the local police to do welfare checks on Mr. Z, as he deteriorated psychiatrically and became more delusional.

During the following months, as the patient continued to decompensate, he became increasingly hostile, and made it known that he was annoyed with the female resident for not communicating with him. He left telephone messages saying that he was thinking of "assassination and murder," and "rape." He associated the resident with "fox-vixens" and "prostitutes," and sent a letter stating that he needed to see her and was planning to do so.

The resident by then had learned that he had been obsessed with a female psychiatrist with whom he had contact 10 years ago, that he had continued to harass, and also had attempted to sue her. He had also stalked and harassed a female graduate student to the point that she left the state. He had also assaulted another female therapist, struck her, knocked her down, and tried to run her over with a car. For this last charge, he spent minimal prison time. Mr. Z apparently would go to slaughterhouses to take photographs of the animal carcasses and send these pictures to the female object of his delusions. He would also collect feces samples from animal petting zoos and send them to these people. It appeared that the patient had never been delusion-free nor hallucination-free even while on medication, with pronounced erotic delusions manifesting with women therapists over several years.

The local police, who initially had refused to pick him up on a 72-hour hold, eventually took him to the county hospital, where he was held for 180 days for danger to self and others.

## CASE REPORT #2

Mr. X, a 35 year old single Caucasian, with the diagnosis of bipolar disorder, had received treatment at various medical centers over a period of 10 years. He had disliked most of his treating psychiatrists, and had opted to be followed by his primary care physician who treated him with lithium. He had a break-through episode of mania while on lithium, and began to receive care from a female psychiatric resident.

Mr. X did fairly well through the first several months of treatment, and had a positive transference towards the treating physician. He was seen weekly for therapy and medication management. After approximately a year of treatment, he began to feel that he did not suffer from bipolar disorder, and his denial of the illness was addressed in therapy. Meanwhile, he

began to miss scheduled appointments, and soon became noncompliant with his medications. There was a gradual transition from positive transference to an unrealistic obsession with the treating psychiatric resident. The patient moved into a rental property close to the medical center, within walking distance of the psychiatric office building. He showed up twice in the resident's office without appointments. He claimed to have a job at the medical center and had a new post office box address at the center.

Shortly thereafter, Mr. X refused to come in for scheduled appointments, but requested that the resident visit him at his apartment. He came one last time to the office, became extremely angry and stated that he felt like punching the face of the resident. He left without incident, and then began writing numerous letters to the resident. The frequency of the letters gradually increased, with as many as three letters being sent within the same day. The content of the letters was bizarre, sexually preoccupied, and written about the patient's search for "ONE girlfriend . . . a pretty intelligent girl with a diamond ring on her finger who would sleep with me every night." "I need a girlfriend who loves golf, skiing and SEX who will ask me to marry her." There were various newspaper cuttings, pictures of skimpily clad women, and pictures of himself included with the letters.

The resident discussed the case with several supervisors, who agreed that the patient was in a manic/psychotic state, and various treatment options were discussed. The patient himself requested that his care be terminated and refused to show up for his appointments. It was clear that there was manifestation of erotic transference, but the patient being in a manic state brought up the issues of safety for the community and the patient himself. The resident consulted with a forensic psychiatrist, who recommended that the resident terminate the care as requested by the patient. Concern for the patient's, as well as the resident's safety was expressed, and the best possible treatment options for the patient were discussed.

Mr. X did not meet criteria for an involuntary hold. A letter of termination was sent to the patient by certified mail with return receipt due, offering treatment options for follow-up care. A few days later, the resident received a letter from the patient, type-written and more contained than the previous bizarre correspondence. Mr. X was glad to hear that the resident had terminated care as requested. He intended to follow up with his internist, but preferred not to seek psychiatric care at this time. All supervisors were in agreement that this was the best course of action for the patient.

## DISCUSSION

What is of particular concern is the fact that when a treating physician has to contend with threatening/delusional patients, the issue of personal safety for the care-giver is often never addressed. In the case of establishments like teaching hospitals and medical centers, there is fear of litigation, and administration is usually slow to respond to issues of safety for the health care providers. In both vignettes, the potential dangerousness of the situation was underplayed, by all involved including the residents themselves. This partly arises from our training to put the welfare of our patients before our own. To believe that situations like these can be easily managed is nothing short of a delusion of control!

Understanding the different types of stalking behavior, be it erotomaniac stalking of therapist, obsessional following of a work colleague, or harassment by a jealous estranged spouse, is essential in planning an anti-stalking strategy. The stalker's behavioral history should be elicited, including criminal history, especially convictions

for crimes involving harassment and/or violence, evidence of substance abuse, and other indicators of anti-social, threatening behavior. A multidisciplinary approach to stalking works best, with the law enforcement agency working with the judicial system, correctional and social services agencies, and community organizations. Social service providers may be able to recruit the help of the suspected stalkers' family, friends, or associates in securing appropriate treatment for the stalker.

The following procedures are suggested for therapists dealing with patients who harass or threaten violence:

1. Assess the situation and if appropriate begin with conservative measures that are likely to be effective, such as talking to the patient and requesting that the inappropriate conduct cease.
2. If patient does not heed the request, follow by a letter sent to the patient with return receipt request, describing the offending conduct and either request that the action cease or inform patient that he or she can no longer obtain care in the medical center.
3. If the patient is to be denied further care, caution should be exercised to avoid abandonment of care. Reasonable efforts should be made to assist the patient in finding alternative sources for health care including providing an appropriate list of alternate health care entities and agreeing to continue care until the patient has had a reasonable amount of time to transfer his or her care.
4. Document all contact and communication with patients who behave in a threatening manner. Copies of letters, transcribed telephone messages, notes of conversations (preferably verbatim), and diaries of patient contact are all in order.
5. Notify immediate supervisor, as well as hospital counsel or risk manager, to obtain guidance as to what further measures are warranted.

If conservative measures fail, legal measures may be warranted:

1. Filing a complaint for obscene telephone calls.
2. Arresting for trespassing.
3. Obtaining a temporary restraining order. This measure can be taken to obtain quick relief from harassment in cases where great or irreparable injury is threatened. In California, this order can be obtained with motion papers and signed declarations without the need for the victim to appear in court. The restraining order is in effect for 15 days, after which a court hearing is held to determine if the victim can obtain an injunction against harassment.
4. Obtaining an injunction against harassment. An injunction can be obtained for up to three years.

## CONCLUSION

The case histories emphasize how important it is for us to take threats seriously and address issues of safety. In our medical training, we learn to put patient's welfare before our own, which makes it easy for us to underestimate or deny the potential

danger in certain situations. We have recommended a few general guidelines that may be useful, however each individual case needs to be assessed carefully and particular concerns addressed. Although there have not been many reports of harassment of physicians/therapists by patients, it is imperative that all health care entities have policies and procedural guideline in place to prevent care-givers from becoming victims.

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